DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop C1-05-17
Baltimore, Maryland 21244-1850

Health Plan Benefits Group

DATE: **June 19, 2003**

TO: **All Managed Care Organizations**

FROM: **Director, Division of Enrollment and Payment Operations**

SUBJECT: **2004 Managed Care Enrollment and Payment Systems Changes – ACTION**

Instructions for the 2004 Contract Year were released on June 6, 2003, and contained several items related to enrollment and payment. The purpose of this letter is to provide you with more specific information on these changes and the instructions you need to update your systems and reporting for next year. Operational details for the following items are addressed:

- The revised formats for the Monthly Membership Report (MMR) and Data File are presented. These changes are needed to support the 2004 risk adjustment process.
- The new H-Number factor Working Aged Process is explained; including how to submit data to CMS for your members. This new process will replace the current monthly beneficiary-level reconciliation process. Please note the differences in the survey schedule for 2004 versus 2005 due to transition.
- Clarification is provided regarding the reporting of Employer Group status for your members.
- Direction is given on the default application signature date to be used when submitting transactions to report plan benefit package (PBP) changes related to some passive elections.

NOTE: The items on the monthly membership report changes and on the reporting of employer group status apply to both Medicare+Choice (M+CO) and Cost-Based Organizations. The revised Working Aged process and the section on Application Signature Date and Passive Elections apply only to M+COs and PACE.

Monthly Membership Data File/Report

The risk adjustment payment method is changing for 2004. Details of the new payment method are contained in the Advance Notice of Methodological Changes for Calendar Year (CY) 2004 Medicare+Choice (M+C) Payment Rates, dated March 28, 2003. It is located at the CMS website http://cms.hhs.gov/healthplans/rates/2004/45day.pdf.

CMS will be using the CMS/HCC model instead of the PIP-DCG model to produce the risk adjustment factors. This will result in the production of multiple factors per beneficiary. In addition, the blended payment percentages are changing to 70% demographic and 30% risk adjustment. Finally, the use of the lagged risk adjustment factor will be eliminated for most M+COs by mid-2004.

The changes include the following.

- The PIP-DCG score is obsolete under the new model. It will be replaced by multiple disease groupings; up to 64 are possible for a member. They will be displayed on a separate report available in GROUCH.
- The enhanced CHF payment process ends in 2003.
- The previously disabled ratio reverts to a flag.
- There will still be a Part A and B risk factor; but there will be 3 possible factor types at the beneficiary-level.
- For some demonstration organizations, an MCO-level frailty factor will be included in the risk adjustment factors for some of their members.
- A field has been added to the membership report to identify that the payment was based on a lagged factor.
- A field has been added to support anticipated legislation related to a drug subsidy.

The revised membership file/report layouts are attached. We have added four new fields to these reports and some of the current fields will become obsolete for 2004. The following chart summarizes the report changes.

DISEASE GROUPINGS/PIP-DCG	DISEASE GROUPINGS replace the PIP-DCG but are too numerous to be added to the membership report. This information will be reported to you via a separate report. We expect to provide the format to you in early July. The PIP-DCG will only be populated for pre-2004 adjustments.
CHF FIELDS	All of the CHF fields are obsolete; they will not be populated on any subsequent reports.
PREVIOUS DISABLED RATIO	The RATIO is obsolete as the averaging of the factors based on age no longer will occur. The CMS-HCC model includes this status, as applicable, in the risk adjustment factor provided for the member. The RATIO will be reported on pre-2004 adjustments on the data file version and will be removed from the formatted report version.
RA FACTOR TYPE CODE	There are 3 possible types of factor (expanding to 9 in 2005). Definitions are

	included below.
PREVIOUS DISABLED FLAG	The FLAG indicates if the risk factor includes this element. The CMS-HCC model includes this status, as applicable, in the risk adjustment factor provided for the member. The FLAG will be reported for post-2003 payments and adjustments.
*DEFAULT INDICATOR	Pre-2004, this field was set to Y for members with less than 12 months of Medicare. Effective 1/1/2004, this field will be set to Y if the managed care system lacks a risk adjustment factor and must compute one. See note below.
LAG INDICATOR	In mid-2004, risk adjustment factors will be based on Jan-Dec 2003 data. These nonlagged factors will replace the lagged factors (lagged is based on Jul02 – Jun03 data) for most M+COs. A Y will be populated when the lagged factors are used. NOTE: This INDICATOR will be set to Y for all M+COs until mid-2004. It will continue to be a Y for M+COs that opt out of using the nonlagged factors.
Future Use Flag	This field supports anticipated legislation related to a possible drug subsidy. If this field is set to Y, the member is impacted by the new provision.

*DEFAULT INDICATOR – Prior to 2004, CMS computed factors for all Medicare beneficiaries; those in managed care and in fee-for-service. This indicator was set to Y whenever a new Medicare beneficiary enrolled in an M+CO. After 2003, CMS will compute risk adjustment factors for managed care members only. If, during the payment year, a beneficiary enrolls in an M+CO from fee-for-service Medicare, there will be no computed risk adjustment factor available. The managed care system will develop a factor using the New Enrollee table. The Default Indicator will be set to Y and the Factor Type will be New Enrollee. If the member is not new to Medicare, the correct factor will be provided in the next factor update and payment adjustments will be made at that time.

RA Factor Type Codes

For 2004, there will be 3 different types; 2 for enrollees with at least 12 months of Medicare and 1 for new enrollees (less than 12 months). In 2005, this will be expanded to 9 different types; 5 for enrollees with at least 12 months of Medicare, 3 for new enrollees (less than 12 months) and 1 that applies to both. The additional factors support the risk adjusted ESRD payment method. Please note that the determination of the

community and institutional statuses is based on the information contained in the CMS system - Minimum Data Set (MDS). MDS data is populated by skilled nursing facilities and long-term care facilities. New Enrollee status is based on CMS's Enrollment Data Base.

CODE	NAME	DESCRIPTION	APPLIES TO
C	Community	Beneficiary is not institutionalized or, per MDS, is institutionalized, but for less than 90 days.	Experienced
CP	*Community/Post-Graft	Beneficiary is not institutionalized or, per MDS, is institutionalized, but for less than 90 days. The beneficiary also has had a successful kidney transplant and is no longer dialyzing.	Experienced
D	*Dialysis	Beneficiary is undergoing dialysis treatments.	Experienced
I	Institutional	Per MDS, the beneficiary is institutionalized for 90 or more days. This factor is NOT impacted by institutional transactions submitted by MCOs, this is strictly long-term care as reported in the MDS.	Experienced
IP	*Institutional/Post-Graft	Per MDS, the beneficiary is institutionalized for 90 or more days. This factor is NOT impacted by institutional transactions submitted by MCOs, this is strictly long-term care as reported in the MDS. The beneficiary also has had a successful kidney transplant and is no longer dialyzing.	Experienced
E	New Enrollee	Beneficiary has less than 12 months of Medicare coverage.	New
ED	*New Enrollee/Dialysis	Beneficiary has less than 12 months of Medicare coverage. Beneficiary is undergoing dialysis treatments.	New
EP	*New Enrollee/Post-Graft	Beneficiary has less than 12 months of Medicare coverage. The beneficiary also has had a successful kidney transplant and is no longer dialyzing.	New

G	*Graft	Beneficiary has received a kidney transplant. This factor will be used to compute payment for 3 months. After this 3-month period, the factor reverts to the Dialysis factor (graft unsuccessful) or the Post-Graft factor (graft successful).	Both

*These factor types are related to the risk adjustment ESRD payment process. This process is deferred until 2005 for M+COs. In 2004, they will be used only for computing payments for members of the ESRD Demonstration plans.

The new fields have been added to the Filler at the end of the Data File format. The length remains 200, but the data extends to 194 (from 188 in 2003).

To fit the new data on the Formatted Report, we have reorganized some of the information as follows.

100% DEMOGRAPHIC/RISK ADJUSTMENT PAYMENT AMOUNTS	These fields have been deleted. Effective with the January 2004 version, only the Blended Payment Amounts will display.
PBP ID	The PBP ID has been moved further to the left of the report under the state and county code. This allows the Lag Indicator to be near the other risk adjustment items.
FRAIL	The MCO-level Frailty Factor Flag has been added.
PRDIB	The Previous Disabled Flag has been added.
FTYPE	The Type of Factor has been added.
LAG	The Lag Indicator has been added.
FUTURE USE FLAG	A one field flag has been added

As with the Data File version, the PIP-DCG will only appear on pre-2004 adjustments and the CHF fields have been removed.

Working Aged Process

The working aged (WA) status payment process is changing from a monthly beneficiary specific calculation to an annual survey used to calculate a contract level H number factor. M+COs will identify their working aged members based on a survey of their members of record on the March MMR. CMS will compute an M+CO-level factor that will be applied to the organization's monthly payment. Payments for Hospice, ESRD

and Disabled members and pre-2004 adjustments will be removed from the monthly total prior to application of the WA factor. This factor will remain in place for the payment year.

M+CO Activities
In order for CMS to compute the factor, M+COs must perform the following actions.

- Survey members as reflected by the March 2003 monthly membership report. **Note:** For 2004, if a survey has been conducted for a member(s) within the last 12 months (since August 2002), you need not re-survey. Beginning in 2005, this survey must have been conducted within the same year; i.e., January – September.

- For members that are defined as working aged, report member-level information to CMS in an EXCEL spreadsheet, as follows

1	Name the spreadsheet "Working Aged.2004.HXXXX", X = your contract number
2	Fields on the spreadsheet are "Medicare HIC#, Last Name, First Initial and Date of Birth"

- For members that are NOT defined as working aged, report nothing.

- For nonrespondents, report member-level information to CMS in an EXCEL spreadsheet, as follows

1	Name the spreadsheet "Nonrespondents.2004.HXXXX", X = your contract number
2	Fields on the spreadsheet are "Medicare HIC#, Last Name, First Initial and Date of Birth"

- **M+COs must submit this data via diskette by December 15, 2003 to**

  CMS
  C/O Angela Wright
  C1 -05 - 07
  7500 Security Blvd.
  Baltimore, MD 21244

- Please confirm that you have sent this data by e-mail listing a contact person (with an e-mail address and telephone number) to

  KMIEGEL@CMS.HHS.GOV
  AWRIGHT@CMS.HHS.GOV

Upon review of the diskettes, CMS will confirm receipt of your data.

CMS Activities
Upon receipt of the data CMS will perform the following actions.

- CMS will set the working aged flag to Y on the Monthly Membership report for members that you have reported as well as nonrespondents that reflect this status in CMS systems as of March 2003.

- CMS will compute an M+CO-level factor as follows.

1	Determine the March 2003 monthly payment including those specified members @ the working aged status. Payments for Hospice, ESRD and Disabled members will be excluded.
2	Determine the March 2003 monthly payment including those specified working aged members @ nonworking aged rates. Payments for Hospice, ESRD and Disabled members will be excluded.
3	To obtain the M+CO's working aged factor = #2 - #1 and divide by #2.
4	Multiply this working aged factor by each month's net payment (excluding payments for Hospice, ESRD and Disabled members).

EXAMPLE
March 2003 MMR has 150 enrollees in this contract:

• 3 Working Aged @ $550 per capita, normal (**non-WA**) rates	+1650.00
• 144 non-Working Aged @600 per capita, normal rates	+86400.00
• 1 Hospice	+ 0.00
• 1 ESRD	+ 0.00
• 1 Disabled	+ 0.00
	$88050.00
• 3 Working Aged @ $250 per capita, **WA rates**	+750.00
• 144 non-Working Aged @600 per capita, normal rates	+86400.00
• 1 Hospice	+ 0.00
• 1 ESRD	+ 0.00
• 1 Disabled	+ 0.00
	$87150.00

$$\text{Contract-level WA Factor} = \frac{88050 - 87150}{88050} = \mathbf{0.01022}$$

Now, as of January 2004, assume this contract has two more Working Aged enrollees (for a total of 5) and one less non-Working Aged enrollee. Total enrollment stands at 151:

- 5 Working Aged @ $550 per capita, normal rates +2750.00

• 143 non-Working Aged @600 per capita, normal rates	+85800.00
• 1 Hospice	+ 0.00
• 1 ESRD	+ 0.00
• 1 Disabled	+ 0.00
	+88550.00
	* **0.01022**
Contract-level Working Aged Adjustment =	**$-904.98**

- CMS will report this factor to you on your Plan Payment Report.

- CMS will apply this factor to your net monthly payment beginning with the April 2004 payment. NOTE: The first adjustment will cover the Jan-Apr 2004 timeframe. Beginning in 2005, the WA factor will be applied beginning in January of each year.

- CMS will report this amount under Plan Adjustments on your Monthly Plan Payment Report.

- CMS will continue to apply adjustments to the working aged status for retroactive correction requests submitted for pre-2004 timeframes. CMS will continue to accept WA corrections from M+COs for pre-2004 timeframes until the systems cut-off day in December 2004.

Reporting of Employer Group Status

During 2004, CMS will begin to track the enrollment of employer group health plan (EGHP) members. MCOs will be required to report this information to CMS. This reporting will occur in three ways based on what type of plan your member is enrolled in and will be reported to CMS after the transition to the Medicare Managed Care System in May of 2004.

Method 1 – M+COs Only – Current Members

If your organization offers employer group-only plans, you need only report the associated plan benefit package number. CMS will assume all members of such plans are EGHP members. To report EGHP members that have not elected an EGHP-Only plan, you must use Method 2

Method 2 – M+C and Cost-Based Organizations – Current Members

You must submit a listing of your EGHP members. The Medicare HIC#, Last Name, First Initial and Date of Birth must be reported.

Method 3 – M+C and Cost-Based Organizations – New Members

In mid to late-2004, the current managed care enrollment system will be replaced by the new Medicare Managed Care System (MMCS). After conversion, MCOs will submit employer group status for new members upon enrollment. A new field will be added to the Enrollment Transaction for this purpose. See Attachment B. Also, beginning January 2005, an EGHP Flag will be add to the MMR.

This data will not be required until mid-2004. Prior to that time, final details relating to the (1) submittal process and (2) testing with the revised enrollment transaction will be provided.

Default Application Signature Date and Passive Elections

In some circumstances, CMS allows you to move your members to alternate plans under your organization without a signed application. This is referred to as a "passive election". The plan is basically the same, but the plan number is changing due to administrative reasons. In these cases, the M+CO submits election transaction types 71. On such transactions, the application signature date is required. Since the member has not signed an application for this move, a default date may be used. You are instructed to use the first day of the month of the month preceding the effective date of the plan change.

EXAMPLE
Transaction Type = 71
Effective Date = 20040101
Application Signature Date = 20031201

Contact Information

If you have any questions regarding this letter, please contact the central office staff listed below for the region where your MCO is located.

Boston:	Jacquline Buise (410)786-7607 Jbuise@cms.hhs.gov
New York:	Juan Lopez (410)786-7621 Jlopez@cms.hhs.gov
Philadelphia:	James Dorsey (410)786-1143 Jdorsey1@cms.hhs.gov
Atlanta:	Brenda Hicks (410)786-1159 Bhicks2@cms.hhs.gov
Chicago:	Janice Bailey (410)786-7603 Jbailey1@cms.hhs.gov
Dallas:	Joanne Weller (410)786-5111 Jweller@cms.hhs.gov

Kansas City: Gloria Webster
(410)786-7655
Gwebster@cms.hhs.gov

Denver: Luigi Distefano
(410)786-7611
LDistefano@cms.hhs.gov

San Francisco: Ed Howard
(410)786-6368
Ehoward1@cms.hhs.gov
OR
Jim Logan
(410)786-7623
Jlogan@cms.hhs.gov

Seattle: David Evans
(410)786-0412
Devans2@cms.hhs.gov

Sincerely,

Marla K. Kilbourne

Attachments

CC: Health Plan Benefits Group Managers
RO HMO Coordinators
DEPO

ATTACHMENT A – MMR DATA FORMAT

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
6	First Initial	1	39-39	
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
	Demographic Health Status Indicators:			
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Working Aged	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional

#	Field Name	Len	Pos	Description
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid	1	66-66	Y = Medicaid Status
	Risk Adjuster Indicators:			
20	FILLER	1	67-67	SPACES
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
*22	PIP-DCG	2	69-70	PIP-DCG Category - **Only on pre-2004 adjustments**
***23**	**Default Indicator**	**1**	**71-71**	Y = default RA factor in use • For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
	Fields 26 - 30 applicable to both Demographic and Risk Adjuster:			
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	99 Always Spaces on Payment
29	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD

#	Field Name	Len	Pos	Description
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-$$$$$.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-$$$$$.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-$$$$$.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-$$$$$.99
35	Blended Paymt/Adjustmt Rate A	9	144-152	-$$$$$.99
36	Blended Paymt/Adjustmt Rate B	9	153-161	-$$$$$.99
37	Total Paymt/Adjustmt	9	162-170	-$$$$$.99
	Additional Risk Adjuster Indicators:			
*38	FILLER	1	171-171	SPACES
39	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
40	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – **Only on pre-2004 adjustments**
41	FILLER	1	183-183	SPACES
42	FILLER	1	184-184	SPACES
43	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999

#	Field Name	Len	Pos	Description
44	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
*45	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community CP = Community Post-Graft (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) EP = New Enrollee Post-Graft (ESRD) G = Graft (ESRD) I = Institutional IP = Institutional Post-Graft (ESRD)
*46	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
*47	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – **Only on post-2003 payments/adjustments**
*48	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
*49	Future Flag Indicator	1	194-194	Y = Member eligible for new provision
*50	FILLER	6	195-200	Spaces

ATTACHMENT B

Enrollment/Disenrollment Transaction

Field	Size	Position	Remarks
Claim Number	12	1 - 12	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
Surname	12	13 - 24	Beneficiary Surname
First Name	7	25 - 31	Beneficiary Given Name
Middle Initial	1	32	Beneficiary Middle Initial
Sex	1	33	Beneficiary Sex Identification Code 1 = Male 2 = Female 0 = Unknown
Date of Birth	8	34 - 41	Beneficiary Birth Date; YYYYMMDD format
EGHP Flag	**1**	**42**	**Y = EGHP member**
PBP Identifier	3	43 – 45	Identification number of Plan Benefit Package
Filler	1	46	Spaces
Contract Number	5	47 - 51	Contract Number
Application Signature Date	8	52 - 59 signed	Date the applications was YYYYMMDD format
Transaction Code	2	60 - 61	Beneficiary GHP Transaction Type Code 51 = Disenroll 60 = Employer Group Enroll* 61 = Enroll 71 = PBP Election
Disenrollment Reason	2	62 - 63	Disenrollment reason code
Effective Date	8	64 - 71	Transaction Effective Date; YYYYMMDD format
[Filler]	8	72 - 79	Spaces
Prior Commercial	1	80	Beneficiary GHP Prior Commercial Month Count 0 - 9, A - F = number of months a beneficiary was enrolled in Plan on a commercial basis prior to Plan's Medicare contract; otherwise, blank

ATTACHMENT C – MMR REPORT FORMAT

[EXISTING FORMAT]

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|----+----1----+----2----+----3----+----4----+----5----+----6----+----7----+----8----+----9----+----0----+----1----+----2----+----3--


   RUN DATE:YYYYMMDD                          MONTHLY MEMBERSHIP REPORT                                    PAGE:        9
   PAYMENT MONTH:YYYYMM                    PLAN: H9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                                                 PAYMENT DATE   DEMOGRAPHIC PAYMENT
                                AGE                            M   C A D MTHS     START   END      PART A      PART B
                                GRP                H E   I   C   H D E A B     ----------------------------------
                     S          ---         OUT    O S   N N A   F D F --- ADJ ***** RISK ADJUSTMENT PAYMENT *****
   CLAIM             F E DATE OF  DMG  STATE OF PART S R W S H I     O A PIP REA FCTR-A FCTR-B     PART A      PART B    TOTAL
   NUMBER      NAME  I X  BIRTH   RA   CNTY AREA A B P D A T C D     N U DCG CDE PBP-ID PRDIB                           AMOUNT
_____________________________________________________________________________________________________________________________
 ***[PAYMENT FORMAT]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC  Y  Y Y Y Y Y Y Y Y   Y Y Y 1 1     YYYYMM YYYYMM $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
                           9999                                    Y      99     9.9990 9.9990 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
                                                                   Y               999 9.9990 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
***[ADJUSTMENT FORMAT]***
   AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC  Y  Y Y XXXXXXXXXXXX    Y YZ9Z9  99 YYYYMM YYYYMM $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
                           9999                                         99     9.9990 9.9990 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
                                                                                 9.9990 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99

***[NEW FORMAT A]***
|----+----1----+----2----+----3----+----4----+----5----+----6----+----7----+----8----+----9----+----0----+----1----+----2----+----3--


  RUN DATE:YYYYMMDD                          MONTHLY MEMBERSHIP REPORT                                        PAGE:        9
  PAYMENT MONTH:YYYYMM                    PLAN: H9999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                                                                 PAYMENT DATE       BLENDED PAYMENT
                                AGE  STATE O  P P          M  F P A D MTHS     START   END
                                GRP  CNTY  U  A A H E   I   C  R R D E A B     ------------------------------------------------
                     S          ---  ----- A  R R O S   N N A  A D D F --- ADJ  FCTR-A FCTR-B
  CLAIM              F E DATE OF  DMG  PBP  --  T T S R W S H I  I I O A PIP REA ------------------------------------------------
  NUMBER      NAME   I X  BIRTH   RA   ID  FLAG A B P D A T C D  L B N U DCG CDE  LAG    FTYPE       PART A      PART B   TOTAL AMT
  ___________________________________________________________________________________________________________________________
 ***[PAYMENT FORMAT]***
  AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC Y  Y Y Y Y Y Y Y Y  Y Y Y Y 1 1      YYYYMM YYYYMM
                           9999 999                                    ___      9.9990 9.9990
                                                                       Y        XX     $ZZZ,ZZ9.99 $ZZZ,ZZ9.99 $ZZZ,ZZ9.99
***[ADJUSTMENT FORMAT, POST-2003]***
  AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC Y  Y Y XXXXXXXXXXXX Y Y Y YZ9Z9  99   YYYYMM YYYYMM
                           9999 ___                                    ___      9.9990 9.9990
                                                                       Y        XX     $-ZZ,ZZ9.99 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
***[ADJUSTMENT FORMAT, PRE-2004]***
  AAAAAAAAAAAABBBBBBBC D YYYYMMDD 9999 SSCCC Y  Y Y XXXXXXXXXXXX _ Y Y YZ9Z9  99   YYYYMM YYYYMM
                           9999 ___                                    99       9.9990 9.9990
                                                                       _        __     $-ZZ,ZZ9.99 $-ZZ,ZZ9.99 $-ZZ,ZZ9.99
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